National AOD Workforce Development Strategy

Submission By: Australian Alcohol and other Drugs Council

AADC Submission to the National Workforce Development Strategy Consultation 2022

About us

The Australian Alcohol and other Drugs Council (AADC) is the national peak body representing the alcohol and other drugs sector, comprising: specialist health services working to prevent and reduce harms which can be associated with the use of alcohol and other drugs; practitioners working in alcohol and other drug treatment settings and the areas of prevention and early intervention; researchers and policy specialists dedicated to building the evidence-base to support robust and evidence-based practice and programs; and people who use or have used alcohol and other drugs, and their families.

Our purpose

We work to advance health and public welfare through achievement of the lowest possible levels of alcohol and other drug related harm by promoting effective, efficient and evidence-informed prevention, treatment and harm reduction policies, programs and research at the national level.

Our reach

Through our members, AADC represents:

- over 430 specialist treatment and harm reduction services nationwide, including more than 80% of the non-government organisations that receive federal funding to deliver services and support to people using alcohol and other drugs
- professionals working within the specialist alcohol and other drugs field, representing all treatment types including counselling, detoxification, residential and non-residential rehabilitation, opiate replacement therapy, and harm reduction services, and
- people who use or have used alcohol and other drugs, and their families.

AADC's members are:

- Alcohol Tobacco and Other Drug Association ACT (ATODA)
- Alcohol, Tobacco and other Drugs Council Tasmania (ATDC)
- Association of Alcohol and other Drug Agencies Northern Territory (AADANT)
- Australasian Therapeutic Communities Association (ATCA)
- Australian Injecting & Illicit Drug Users League Inc (AIVL)
- Drug and Alcohol Nurses of Australasia Inc (DANA)
- Drug Policy Modelling Program (DPMP)
- Family Drug Support - FADISS Ltd
- National Indigenous Drug and Alcohol Conference (ADAC)
- Network of Alcohol and other Drug Agencies (NADA)
- Queensland Network of Alcohol and other Drug Agencies (QNADA)
- South Australian Network of Alcohol and Drug Services (SANDAS)
- The Australasian Professional Society on Alcohol and other Drugs (APSAD)
- Victorian Alcohol and Drug Association (VAADA)
- Western Australian Network of Alcohol and other Drug Agencies (WANADA)

This submission

The contents of this submission are based on member discussions held during a workshop with representatives from NCETA on 16 February, 2022 and additional comments provided by members prior to and following that meeting.

Due to the content of these discussions and the varied issues and priorities expressed by our members, we have framed our submission against the key questions used in NCETA's consultations regarding priority issues and actions for the revised *National AOD Workforce Development Strategy*, rather than the detailed discussion questions presented in NCETA's *Review and Revision of the National Alcohol and Other Drug (AOD) Workforce Development (WFD) Strategy: Discussion Paper*.

A number of the recommended actions this submission offer opportunities for discrete projects which could be advanced at the federal level, undertaken with appropriate collaboration with state and territory jurisdictions.

The priority issues and actions for the revised National AOD Workforce Development Strategy

The need for an industry plan that prepares the sector to respond to future needs

Members identified the need for any workforce development strategy to be positioned within a long-term forward plan for the alcohol and other drugs (AOD) sector, starting with a formal industry plan which positions the sector as credible, viable and attractive to work in and addresses:

- the proper calculation of future service demand and need for decisions as to whether funding would increase to be commensurate with demand;
- growing the service system and its workforce to adequately respond to demand, with appropriate resourcing and lead-times to enable this;
- contextualising the AOD workforce and challenges such as worker shortages within the workforce issues facing the broader health and community services workforce;
- building on existing and new areas of workforce capability to respond to other priority issues, such as working with clients with co-occurring needs and conditions across areas including domestic and family violence and mental health; and
- identifying opportunities for collaboration to build total workforce capability.

Recommended action: the establishment of a long-term industry plan for the AOD service system which projects long-term demand and delivery of services and identifies a pathway for resourcing them.

Positioning the strategy within the wider funding and health and community services workforce context

Members noted the strategy will operate in an environment of longstanding, chronic underfunding of alcohol and other drug services and that it therefore needs to be clear about which of its components relate to delivering workforce development outcomes in a context of scarcity, and which reflect the best standards of workforce development that could be achieved in an adequately funded future service environment.

The strategy should be explicit about the consequences that occur when workforce needs aren't met including those that are currently being experienced, such as: inequitable access to education and training; variable qualification standards across the jurisdictions; inconsistent care standards; and an inability by the community to access reliable, high quality AOD health care when, where and how it is required.

Members advised that the strategy needs to acknowledge the impact of unmet demand and increased client complexity and the factors that contribute to it, without normalising an expectation that health services ought be hard to access. In particular, there is a need to rebalance the investment in Australia's AOD response by diverting resources currently spent on law enforcement for supply reduction, towards demand reduction and harm reduction approaches.

Members agreed that the strategy needs to be contextualised within the workforce challenges facing the broader human and social services sector, which faces many of the same issues as the AOD sector including substantial projected workforce shortages.

Recommended action: the identification of and investment in clear, actionable strategies which grow the workforce to meet future demand through increased retention and professional development of the existing workforce.

Recommended action: governments to revise the allocations of expenditure across the three pillars of the *National Drug Strategy 2017-2026* and rebalance investment towards increased funding for demand reduction and harm reduction activities.

Implementation of the strategy must be planned and resourced

Members agreed there is minimal value in any strategy not accompanied by a properly-resourced, realistic and actionable implementation plan with effective monitoring and clear accountability for ensuring its delivery. The absence of implementation plans for previous strategies has been a longstanding issue of sector concern and resulted in those strategies' inefficacy.

This issue was reflected in AADC's *2022-23 Budget Submission* which called for the development of a formal implementation and evaluation plan to accompany the revised *National Alcohol and other Drug Workforce Development Strategy* as well as workforce goals contained within the *National Aboriginal and Torres Strait Islander People's Drug Strategy*, with sector consultation to identify the manner and amount of resources required for their implementation and evaluation.

Members reinforced the strategy must be clear regarding who is responsible for funding its activities, be that federal or state/territory governments, or employers. In the event employers are responsible for funding activities contained within the strategy, this must be resourced through additional government investment distributed to service organisations in all funding contracts.

Recommended action: ensure the final strategy is accompanied by a properly-resourced implementation plan, which specifies accountabilities in the delivery of the strategy and its outcomes, offers a framework for its evaluation and identifies the bodies and governance structures responsible for the strategy's management and oversight.

Linking the strategy with related policy, strategy and decision-making at the federal and state/territory levels

Members noted the current absence of national governance structures relating to AOD and a disconnect between federal and state/territory level AOD policy and strategy, let alone separate but related work being undertaken in different portfolios and at various levels of government. Such structures are seen as essential to the successful implementation and evaluation of any future *National Alcohol and other Drug Workforce Development Strategy*. Without such structures, members queried what value the federal government could add to workforce development within the sector and therefore what the purpose of a national strategy would be.

Members noted that much of the funding of services and other workforce-related decision-making occurs at the state/territory level. This raised questions regarding how a national strategy would cascade through to decision-making, and funding allocations, at the jurisdictional level. Members noted that a number of jurisdictions also already successfully undertake activities that relate to the strategy which don't need to be replicated, such as periodical workforce surveys, though some jurisdictions may be stronger in this regard than others.

Whilst members support a national approach, it requires significantly greater clarity regarding the roles of respective governments and the implementation of governance structures to oversee the plan at a national level. Members stressed that the strategy must be able to accommodate initiatives that are jurisdiction-specific or tailored to unique jurisdictional needs whilst still enabling cross-jurisdictional initiatives and improvements on common issues.

Recommended action: design and implement national governance structures relating to AOD, building on AADC's current consultations with its members regarding the principles that should underpin such structures and the State and Territory AOD Peaks Network's recently submitted proposal for a *National AOD Governance Framework*.

Responding to co-occurring needs across the alcohol and other drugs and mental health systems

Members agreed the AOD workforce needs to be able deliver holistic and coordinated services that address the range of biopsychosocial factors that contribute to co-occurring needs for people who use alcohol and other drugs. People experiencing co-occurring mental health and AOD issues in particular should have access to coordinated care; however, members cautioned against simplistic integration of AOD into the mental health system on the basis that past and current attempts to do this across different jurisdictions have resulted in:

- AOD services being deprioritised, diminished and defunded in favour of mental health services;
- increased costs of service due to the higher cost base operating within mental health services;
- inadequate outcomes for consumers; and,
- a loss of specialist AOD practice and policy knowledge and the deterioration of AOD models of care.

AADC's position on the best models for delivering coordinated care for those with co-occurring AOD and mental health issues is outlined in our *Submission to the Department of Health Consultation in response to Recommendations in the Productivity Commission's Mental Health Inquiry Report*.

Members reported that in professional groups where AOD is a specialisation, such as nursing, the integration of AOD and mental health further marginalises the profile and practice of AOD professionals. In integrated services this can lead to AOD specialists being squeezed out in preference to mental health specialists, diminishing total service capability to respond to clients' AOD needs. This marginalisation also acts as a disincentive for professionals to choose AOD as their area of specialisation in the future.

Members identified the need for greater investment in the workforce development, training and education to maintain and enhance the capability of AOD workers to support people presenting with co-occurring mental health conditions, including the need for increased training on trauma-informed care to build knowledge and practice in the field. This again accords with recommendations in AADC's *Submission to the Department of Health Consultation in response to Recommendations in the Productivity Commission's Mental Health Inquiry Report*.

Recommended action: ensure investment to continue to build upon capability in the AOD sector to work with clients with co-occurring mental health issues and partner with mental health services to deliver coordinated care within their respected areas of specialisation.

The scope of the strategy with regard to including generalist with specialist workers

There was a mix of views regarding whether the strategy should confine itself to the needs of the specialist AOD workforce or whether it should also include the generalist workforce responding to AOD issues. Whilst some noted the need for the strategy to include actions which constitute the upskilling of generalist practitioners on AOD issues, particularly with regard to the health workforce in regional areas or specific professional groups such as nurses, others were concerned that incorporating generalists would make the strategy excessively broad and unwieldy and would further dilute prioritisation of the development of the specialist sector.

There was, however, strong consensus that the strategy should have its main focus on the specialist AOD workforce with clear definitions delineating the two. Members stressed the need to continue to elevate AOD as an area of legitimate specialised practice, which was still not well recognised in specific professional groups. This delegitimising of practice was seen as contributing to outcomes such as lower levels of remuneration, absence of adequate workforce pathways, and lack of visibility for AOD as an area of practice. Some members identified that the scope of practice able to be delivered by some groups already established within the sector, such as nurses and workers with lived experience, was not always well understood by others working in AOD and therefore limited its potential use.

Members noted the role that the specialist workforce itself plays in building the capability of the generalist workforce, through working in partnership and offering information, education and pathways for referral. Members also noted that it is the specialist sector that should be informing policy and systems-level development of AOD responses, in order for that system to be strong and robust.

Recommended action: further increase awareness within the AOD sector regarding the skills and scope of practice available through specific practice and professional groups, to ensure they can be fully utilised in service delivery.

Tackling stigma and discrimination as a root cause of workforce issues

Members identified the widespread stigma and discrimination against people who use alcohol and other drugs as directly impacting: workforce attraction and retention; recognition of AOD as a legitimate area of specialised practice; and the provision of adequate funding to resource the AOD sector to meet community needs, with workforce capacity being a key element of this.

AOD nurses reported that stigma led to a perception amongst other nurses that their work is "not real nursing", resulting in diminished standing and respect within their profession. Other members reported community members expressing dismay and even disgust regarding the prospect of working with people who use alcohol and other drugs, which then acts as a disincentive to specialise in the area for those considering careers in related professions.

These contextual factors in aggregate have a wearing effect on those working in the sector, which can contribute to feelings of burnout and disaffection and resultant workforce attrition. Members also identified the impacts of bias and discrimination on the generalist health sector's awareness of AOD issues and its willingness to respond to the needs of people who use alcohol and other drugs.

Members noted the paucity of undergraduate AOD education available for health professionals, with only medical doctors required to undertake study relating to AOD as part of their core curricula. This leads to significant knowledge gaps within the generalist health workforce, and leaves issues of bias and discrimination unaddressed and unchecked. This results in the creation of barriers to access by health professionals who don't want clients who use alcohol and other drugs within their practice.

Finally, members noted a significant shortfall in the availability of elective studies and student placements in the area of AOD available to undergraduates studying in relevant areas. As such, many students aren't even aware of AOD as a potential area of specialisation, let alone provided with the educational background or practice opportunities to establish a pathway into the field.

Recommended action: work with tertiary providers to promote careers in AOD, through the inclusion of core and elective studies in undergraduate degrees, and exposure to AOD practitioners and professionals through guest lectures, student placements and other resources.

Recommended action: implement AOD awareness and harm reduction training for the generalist health workforce, to address stigma and discrimination and improve access to health services for people who use alcohol and other drugs.

The lived experience / peer workforce

Members stressed the strategy's role in recognising the importance of the lived experience / peer workforce (referred to here as the lived experience workforce) and support its inclusion in the definition of AOD specialist workers. This workforce comprises people who use or have used alcohol and other drugs, and also the family members and carers of people who use or have used alcohol and other drugs.

The value of the lived experience workforce in delivering better treatment outcomes was discussed, including improved outcomes for the families and carers of people who use alcohol and other drugs.

Its value also goes beyond service delivery, and is seen as having a vital role to play in the design and implementation of services, organisations and systems within Australia's AOD response system, including through work in the policy and advocacy domain.

Members noted the needs of this section of the AOD workforce are unique and specific. Expanding this workforce through improved career pathways and development support is seen as vital to meeting the AOD sector's future workforce capacity and capability needs.

Members said that specifying in the strategy that support may be provided by the lived experience workforce on a paid or unpaid basis assumed its volunteerism, with obvious implications for undervaluing the role the lived experience workforce and its potential exploitation as an unpaid source of labour. Members proposed the strategy should promote awareness of the lived experience workforce and its role and value amongst specialist AOD workers and also the generalist workforce, to build the standing of the workforce and ensure that peer services can be well integrated into non-peer organisations.

Members discussed the need for improved pathway planning and professional development for lived experience workers, noting some international jurisdictions such as the U.S. have adopted formalised career development approaches that allow lived experience workers to advance over time into highly skilled and senior roles within the AOD sector. There was also discussion of the need to better train managers and supervisors to effectively support lived experience workers, integrate their work within the organisation's practice, and ensure their career advancement isn't negatively impacted by stigma and discrimination within services.

There was discussion around the minimum competencies required to engage in effective lived experience practice, and strategies for supporting lived experience workers to develop additional competencies whilst practising. Members noted the high proportion of workers in the AOD sector who identify as having personal experience relevant to alcohol and other drugs, including the high proportion of these who enter the sector with tertiary qualifications and/or who earn these qualifications subsequently. There was discussion about how some lived experience workers may feel about that title as they advance through their career, identified as a topic for further consultation with the lived experience community.

Recommended action: ensure a clear definition of the lived experience workforce is included in the strategy, comprising people who use or have used alcohol and other drugs, and also family members and carers of people who use or have used alcohol and other drugs.

Recommended action: ensure any definition used of the lived experience workforce doesn't assume a bias towards lived experience workers being unpaid.

Recommended action: in consultation with the lived experience workforce, create formalised career pathways addressing remuneration, support and continued professional development that allow lived experience workers to advance into more senior roles within the AOD sector.

Recommended action: deliver training and development to managers and supervisors within AOD services, regarding the role and integration of the lived experience workforce into non-peer AOD services.

The Aboriginal and Torres Strait Islander workforce

Members prioritised the need for dedicated investment in the development needs of the Aboriginal and Torres Strait Islander workforce. This was in line with the AADC's *2022-23 Budget Submission* which noted that *The National Aboriginal and Torres Strait Islander People's Drug Strategy 2014-2019* has been allowed to lapse with no effort made towards its renewal. It called for the review and update of that strategy and its workforce development goals.

Members identified the need to increase support through resourced strategies to address recruitment, retention and education and training support, particularly for workers operating in regional areas. Some members identified the need for improved career pathways and progression for the Aboriginal workforce, including training to improve skills and knowledge in the areas of management and leadership. These members noted few senior positions allocated or offered to Aboriginal workers, and the need for increased opportunities at the senior clinician level for workers who didn't want to move into management roles.

Recommended action: review and update *The National Aboriginal and Torres Strait Islander People's Drug Strategy 2014-2019* and its workforce development goals and develop a properly-resourced implementation plan aligned with the implementation plan for the revised *National Alcohol and other Drug Workforce Development Strategy*.

Regional-specific workforce challenges and needs

Members identified the need for greater availability of education and training to the specialist AOD workforce in regional areas. Some members noted the lack of AOD education available to the generalist regional health workforce, such as GPs, with local regional AOD services being forced to compensate for this through providing supplementary support and education to generalist health practitioners.

Members also noted the specific recruitment and retention issues experienced by AOD services in regional areas, including the extra time required to recruit appropriate staff and the likelihood that new staff will require additional training to undertake their role. The smaller workforce numbers in regional areas combined with geographic isolation pushes up the cost of education and training, due to the travel and time required to attend metropolitan-based options. Regional employers are rarely able to leverage economies of scale in meeting their professional development needs.

These higher costs of recruitment and development are most commonly borne by the employer. With skilled staff in short supply in regional areas, turnover rates amongst newly-recruited staff are also high with staff often moving on before the employer's investment in their recruitment and training has been recouped.

Recommended action: ensure service delivery funding accommodates the higher costs of staff recruitment and development for regional employers.

Equitable access to affordable, appropriate training

Projects currently operating in the AOD sector indicate high demand for training and development. This reflects an employer preference for AOD workers with formal qualifications, where they can afford to employ them within their funding.

Not all available training is well-regarded, with members reporting many participants find qualifications such as the certificate IV in alcohol and drugs too generic and insufficiently advanced for workers with any practice experience behind them. The quality of the training across the RTOs that deliver the certificate IV appears variable. This qualification was last due for review in 2017 however this was deferred to 2020, then delayed again due to the federal government's review of the training package management system. There are questions regarding whether the qualification is currently fit for purpose. Members also discussed the potential for qualifications tailored to the needs of lived experience workers, as a means of enhancing practice and contributing to formalised career development pathways.

Members from smaller jurisdictions, with regionally-based members or from smaller professional cohorts within the larger AOD sector raised the difficulties of providing training that accommodates the breadth of the sector's training needs and is affordable within funding allocations. Some members raised the possibility of providing workers employed in non-government services with shared access to training being delivered for workers in government services. The potential for national collaboration to open access to shared training and development for workers in smaller and regional jurisdictions was also discussed.

Recommended action: deliver shared access to training and development for workers across sectors and across regions, to enhance availability whilst lowering access costs.

Recommended action: review the current certificate IV in alcohol and other drugs in consultation with the sector, and identify opportunities to improve and expand upon this qualification including through the development of tailored qualifications for lived experience workers.

The adoption of minimum competencies for standardised quality of care

Members discussed the option of establishing minimum training standards or minimum competencies in recognition of the specialised and skilled nature of AOD work. Certificate IV minimum training standards have been adopted in the ACT with great success in large part due to government subsidisation, leading to a more informed and capable workforce. A similar strategy has been less successful in Victoria, and concerns were raised that minimum qualifications standards may exclude some members of the lived experience workforce.

Members noted the value of qualifications and practice capabilities in meeting increasingly complex client needs. They also noted the challenges of establishing minimum standards across the diverse array of practitioners and professional groups working in the sector, each of whom have a critical role to play in successful service delivery. Many of these professional groups, such as nurses, social workers, psychologists and addiction medicine specialists, are already required to have higher education qualifications in order to practice.

There was a general preference to consider minimum competencies, including the articulation of minimum competencies within specific professional groupings, as a strategy that would contribute to consistent standards in the quality of care across jurisdictions whilst allowing necessary flexibility in meeting the needs of the sector's highly diverse workforce.

There was particular discussion of how minimum competencies might apply to the lived experience workforce, and how lived experience capability might be implemented and assessed within organisations and amongst other groups working in the AOD sector. Recommendations relating to qualifications and career pathways for people with lived experience is addressed elsewhere within this submission. There was also some discussion of the need for minimum competencies in AOD within generalist health professions such as nursing etc, to improve access and practice standards when working with people who use alcohol and other drugs.

Recommended action: implement a process of national consultation to establish a consistent set of minimum competencies for AOD workers which will contribute to consistent quality of care standards across all jurisdictions, including identification of groups who currently may not meet these competencies and developmental pathways that will enable them to reach competencies consistent with their specialised area of work.

Recommended action: consider strategies for building and assessing the competency of AOD services and other health professionals in working with people who use alcohol and other drugs.

Workforce attraction, recruitment and retention

Members discussed the additional range of individual and structural issues affecting workforce attraction, recruitment and retention within the AOD sector in supplement to those issues discussed elsewhere in this submission.

Issues frequently experienced at the individual worker level include:

- lack of awareness of AOD as a career pathway combined with issues of stigma and low wages making AOD comparatively less attractive as a career;
- the need for greater collegiate support and supervision, including for workers such as lived experience workers or specific professionals such as nurses who may be the only worker of that type operating in their service;
- greater support for early career workers in particular, with high drop-out rates experienced amongst workers within their first four years working in the sector;
- more reliable access to the training and education required for workers to feel effective and confident in their role;
- inadequate supervisory support due to a lack of effective training for supervisors and managers; and
- lack of career pathways and structured progression opportunities over the long-term.

Members also discussed a series of structural issues driven in large part by government approaches to commissioning, including:

- short-term employment contracts for workers attached to services without long-term, reoccurring or reliable funding;

- delays in government announcements of funding renewal, such as is currently occurring with regard to the *National Ice Action Strategy*, which lead to uncertainty and worker turn-over as staff leave in search of greater financial security;
- the overburdened nature of the service system, in which practitioners consistently and continually face levels of demand which they are inadequately funded to meet, leading to fatigue and burn-out;
- commissioning based on cost of service which doesn't adequately accommodate items, such as but not necessarily confined to clinical supervision, and access to adequate education and training and the necessary time release; and
- attrition from non-government services to the government sector which is able to offer higher salaries and more secure contracts of employment.

Recommended action: increased mechanisms for new graduates to connect and be paired with mentors, including mentors external to their organisation but related to their area of practice when they are the sole practitioner in that space within their home service or organisation.

Recommended action: the design and resource of specific, targeted retention strategies for early career workers and other cohorts considered critical to meeting the future workforce needs of the sector.

Recommended action: greater career pathways planning and development of associated professional development opportunities across the sector, particularly in relation to management and leadership skills.

Recommended action: commissioning bodies to ensure that the overall cost of providing a service includes sufficient and effective methods of worker support, supervision and professional development.

Recommended action: funding certainty through implementation of performance-based contract extensions and introduction of minimum two years' notice on funding expiration or re-tendering processes.

Recommended action: the update of the *Drug and Alcohol Services Planning Model* (DASPM) and the progressive implementation over a multi-year period of funding for the delivery of AOD services commensurate with demand, based on needs-based population planning.

Recommended action: the delivery of a nationally-coordinated campaign to articulate and promote, within the health sector and broader community, the nature and benefits of specialist AOD work and the respective roles of AOD professionals and practitioners across the breadth of AOD practice, as a means of countering stigma and building knowledge and understanding.

The impact of specific workforce shortages, including in opioid treatment programs

Specific workforce shortages amongst specialist AOD and generalist health professionals able to prescribe opioid therapies was raised by a number of members. Shortages were identified as resulting from:

- an unwillingness of doctors trained in pharmacotherapy to work with people who use drugs in their practice due to stigma and bias;
- the detrimental impact on the total availability of opioid substitution therapy (OST) where the small number of GPs who do prescribe at moderate to high volumes temporarily withdraw due to COVID, leaving consumers with no viable alternative options;
- the ageing workforce of current prescribers;
- restrictions on the range of health professionals eligible to prescribe; and
- an unwillingness of pharmacies to dispense.

Recommended action: increase the range and utilisation of health professionals both able and available to prescribe and dispense opioid substitution therapies, including through reversing the expectation that pharmacies will provide OST rather than operating on an opt-in basis.

Recommended action: work with General Practitioners to increase the availability of opioid substitution therapy within their practice, particularly through education which addresses stigma, bias and discrimination affecting their willingness to see clients who use drugs.

Other issues

Members' discussions were wide-ranging, with the following issues also raised:

- the limitations of telehealth and digital access in the future delivery of AOD services, noting the digital divide affecting many people who access AOD services in line with AADC's issues paper on *Telehealth and digital access*;
- the potential to increase the use of technology to rapidly share and disseminate health information across services and jurisdictions, such as in relation to issues within unregulated drug markets;
- reports of workforce attrition resulting in the implementation of COVID-19 vaccination mandates for the health workforce in many states and territories;
- the exacerbation of existing workforce shortages within specific services resulting from absences due to staff contracting COVID-19 or having to self-isolate as close contacts of someone with COVID-19;
- other impacts of COVID-19 on worker wellbeing, such as the effects of practices such as social distancing on lived experience workers and/or other workers with past experience of trauma; and
- the adequacy of current sector workforce mapping and consistency of workforce data collection, with a need to ensure the sector's workforce reflects the diversity of the communities it serves.

Summary of recommendations

- The establishment of a long-term industry plan for the AOD service system which projects long-term demand and delivery of services and identifies a pathway for resourcing them.
  The identification of and investment in clear, actionable strategies which grow the workforce to meet future demand through increased retention and professional development of the existing workforce.
- Governments to revise the allocations of expenditure across the three pillars of the *National Drug Strategy 2017-2026* and rebalance investment towards increased funding for demand reduction and harm reduction activities.

- Ensure the final strategy is accompanied by a properly-resourced implementation plan, which specifies accountabilities in the delivery of the strategy and its outcomes, offers a framework for its evaluation and identifies the bodies and governance structures responsible for the strategy's management and oversight.
- Design and implement national governance structures relating to AOD, building on AADC's current consultations with its members regarding the principles that should underpin such structures and the State and Territory AOD Peaks Network's recently submitted proposal for a *National AOD Governance Framework*.
- Ensure investment to continue to build upon capability in the AOD sector to work with clients with co-occurring mental health issues and partner with mental health services to deliver coordinated care within their respected areas of specialisation.
- Further increase awareness within the AOD sector regarding the skills and scope of practice available through specific practice and professional groups, to ensure they can be fully utilised in service delivery.
- Work with tertiary providers to promote careers in AOD, through the inclusion of core and elective studies in undergraduate degrees, and exposure to AOD practitioners and professionals through guest lectures, student placements and other resources.
- Implement AOD awareness and harm reduction training for the generalist health workforce, to address stigma and discrimination and improve access to health services for people who use alcohol and other drugs.
- Ensure a clear definition of the lived experience workforce is included in the strategy, comprising people who use or have used alcohol and other drugs, and also family members and carers of people who use or have used alcohol and other drugs.
- Ensure any definition used of the lived experience workforce doesn't assume a bias towards lived experience workers being unpaid.
- In consultation with the lived experience workforce, create formalised career pathways addressing remuneration, support and continued professional development that allow lived experience workers to advance into more senior roles within the AOD sector.
- Deliver training and development to managers and supervisors within AOD services, regarding the role and integration of the lived experience workforce into non-peer AOD services.
- Review and update the *National Aboriginal and Torres Strait Islander People's Drug Strategy 2014-2019* and its workforce development goals and develop a properly-resourced implementation plan aligned with the implementation plan for the revised *National Alcohol and other Drug Workforce Development Strategy*.
- Ensure service delivery funding accommodates the higher costs of staff recruitment and development for regional employers.
- Deliver shared access to training and development for workers across sectors and across regions, to enhance availability whilst lowering access costs.
- Review the current certificate IV in alcohol and other drugs in consultation with the sector, and identify opportunities to improve and expand upon this qualification including through the development of tailored qualifications for lived experience workers.
- Implement a process of national consultation to establish a consistent set of minimum competencies for AOD workers which will contribute to consistent quality of care standards across all jurisdictions, including identification of groups who currently may not meet these competencies and developmental pathways that will enable them to reach competencies consistent with their specialised area of work.

- Consider strategies for building and assessing the competency of AOD services and other health professionals in working with people who use alcohol and other drugs.
- Increased mechanisms for new graduates to connect and be paired with mentors, including mentors external to their organisation but related to their area of practice when they are the sole practitioner in that space within their home service or organisation.
- The design and resource of specific, targeted retention strategies for early career workers and other cohorts considered critical to meeting the future workforce needs of the sector.
- Greater career pathways planning and development of associated professional development opportunities across the sector, particularly in relation to management and leadership skills.
- Commissioning bodies to ensure that the overall cost of providing a service includes sufficient and effective methods of worker support, supervision and professional development.
- Funding certainty through implementation of performance-based contract extensions and introduction of minimum two years' notice on funding expiration or re-tendering processes.
- The update of the *Drug and Alcohol Services Planning Model* (DASPM) and the progressive implementation over a multi-year period of funding for the delivery of AOD services commensurate with demand, based on needs-based population planning.
- The delivery of a nationally-coordinated campaign to articulate and promote, within the health sector and broader community, the nature and benefits of specialist AOD work and the respective roles of AOD professionals and practitioners across the breadth of AOD practice, as a means of countering stigma and building knowledge and understanding.
- Increase the range and utilisation of health professionals both able and available to prescribe and dispense opioid substitution therapies, including through reversing the expectation that pharmacies will provide OST rather than operating on an opt-in basis.
- Work with General Practitioners to increase the availability of opioid substitution therapy within their practice, particularly through education which addresses stigma, bias and discrimination affecting their willingness to see clients who use drugs.